ILLINOIS SCHOOL
Insurance Network

Enrollment / Change Checklist

TO BE COMPLETED BY EMPLOYER

Employee Name:	
Reason for Enrollment / Change:	☐ New Hire ☐ Birth ☐ Job Status Change ☐ Marriage ☐ Lost Other Coverage ☐ Other | Describe:_____ ☐ Open Enrollment
Coverage Elected	
Medical Insurance BCBS of IL	☐ Enrolled in HMO ☐ Confirm Medical Group # provided on application
Dental Insurance BCBS of IL	☐ Enrolled in Dental ☐ Waived Dental
Vision Insurance VSP	☐ Enrolled in Vision ☐ Waived Vision

Employee Salary:_____

Benefit Class:_____

Employees: Please submit along with all other required forms to your HR Department contact.

HR Department: Please submit along with all other required forms to:

Illinois School Insurance Network

Email: mwil.isinadministration@marshmma.com

EIN: 36-6005629

Benefit Election & Waiver Form

Chaney-Monge School District 88: Non-Certified School Year Support Staff

Please complete the following election form for your benefits. Select the appropriate reason below for completing this form. If you are choosing not to enroll in any of the benefits offered, and are therefore waiving all coverage, please check the box for waiving coverage under each benefit. The top portion of this form must be completed in its entirety. Form is not valid unless signed.

☐ **Open Enrollment** ☐ **New Hire** ☐ **Qualifying Life Event* (Please Describe)** _____

**Qualifying life events include: involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption.*
*** Please note that all employees will be enrolled in employer-sponsored Basic Life & AD&D.*

REQUIRED INFORMATION

District Name:	Chaney-Monge School District 88	Social Security #:	— —
Employee Name:		Date of Hire:	/ /
Address:		Coverage Effective:	/ /
City, State, Zip:		Telephone #:	— —
Date of Birth:	/ / Gender: ☐ M ☐ F	Marital Status:	
Email:			

Medical Coverage Election

☐ I choose to waive medical coverage for the plan year. **BCBS of Illinois**

BA HMO Plan 4**
B01776

Employee Only	☐
Employee +1*	☐
Family*	☐

*Note: Fill out dependent information below if you elect a tier other than Employee Only.

****If you select HMO, you must provide a Medical Group # and PCP Information below.**

Dental Coverage Election

☐ I choose to waive dental coverage for the plan year. **BCBS of Illinois**

DPPO 1000
270728

Employee Only	☐
Employee + 1*	☐
Family*	☐

*Note: Fill out dependent information below if you elect a tier other than Employee Only.

Vision Coverage Election

☐ I choose to waive vision coverage for the plan year. **VSP**

Vision Plan 175
12019596

Employee Only	☐
Employee + 1*	☐
Family*	☐

*Note: Fill out dependent information below if you elect a tier other than Employee Only.

Dependent Information

Name	Social Security #	Birth Date	Gender	Relationship	Medical	Dental	Vision
	— —	/ /					
	— —	/ /					
	— —	/ /					
	— —	/ /					
	— —	/ /					

Medical PCP Information

THIS INFORMATION IS REQUIRED IF ENROLLING IN MEDICAL HMO PLAN

Name of Enrolled	Medical PCP Name	9-Digit PCP ID Number	3-Digit Medical Group/ IPA Number

Authorization and Signature

Every employee is required to complete this form, in its entirety, either electing specific coverage or waiving coverage completely. Your next opportunity to make changes will be during the next open enrollment period, unless you experience a qualifying life event. Qualifying life events include involuntary loss of coverage, marriage, divorce, legal separation, birth or adoption. If you experience a qualifying life event, please contact your Benefits Department within 30 days of the life status change.

My signature below authorizes Chaney-Monge School District 88 to deduct insurance premiums on a pre-tax basis.

Name: _____ Signature: _____ Date: ____/____/____